DEPARTMENT OF THE NAVY
NAVAL HOSPITAL
BOX 788250
MARINE CORPS AIR GROUND COMBAT CENTER
TWENTYNINE PALMS, CALIFORNIA 92278-8250

IN REPLY REFER TO:
NAVHOSP29PALMSINST 6010.9C
Code 0901
12 March 1997

NAVAL HOSPITAL TWENTYNINE PALMS INSTRUCTION 6010.9C

From: Commanding Officer

Subj: IMPROVING ORGANIZATIONAL PERFORMANCE

Ref: (a) BUMEDINST 6010.13
(b) Joint Commission Accreditation Manual for Hospitals
(c) BUMEDINST 6320.66A
(d) NAVHOSP29PALMSINST 5430.1B

Encl: (1) Naval Hospital Twentynine Palms Performance Improvement Plan
(2) Department Head Responsibilities
(3) Performance Improvement Information Flow Chart
(4) Performance Improvement Cycle
(5) Glossary
(6) Strategic Plan
(7) Vision Statement
(8) Mission Statement
(9) Guiding Principles
(10) PI Management Responsibility for Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Functions
(11) Quarterly Performance Improvement Summary

1. Purpose. The purpose of this plan is to facilitate the process of transition from a “stovepipe” departmental 10 step model of monitoring and evaluation to full implementation of an organizational performance model using the FOCUS-PDCA cycle, per references (a) and (b). It shifts the primary focus from the performance of individuals to the performance of the organization’s systems and processes, while continuing to recognize the importance of the competence of each staff member. It describes the structure and process to accomplish this transition.

2. Cancellation. NAVHOSP29PALMSINST 6010.9B.

3. Background. References (a) and (b) promote creating an environment that fosters continuous performance improvement efforts to support the Command Mission. This includes measuring and assessing the important functions defined in reference (b) in a planned, systematic, interdisciplinary and collaborative manner.

4. Responsibilities

a. Commanding Officer, Naval Hospital Twentynine Palms. The Commanding Officer is the Bureau of Medicine and Surgery's representative, the privileging authority, and the Chief Executive Officer and is actively involved in continuous improvement as Chairman of the Board of Directors (BOD). The Commanding Officer has ultimate authority and can over-ride the BOD. Using the mission, vision, guiding principles, and strategic goals, the Commanding Officer provides direction and resources, sets priorities for improvement and empowers the staff in performing continuous performance improvement.

b. Executive Officer. The Executive Officer acts for the Commanding Officer in his/her absence and is responsible for overseeing and guiding the Performance Improvement Program.

c. Board of Directors. The BOD is comprised of the Commanding Officer, Executive Officer, Hospital Directors, Comptroller, and Command Master Chief. This advisory council consists of the hospital's senior leadership which meets daily to inform the Commanding Officer on major policy, resource, process improvement, and managed care issues.

d. Executive Committee of the Medical Staff. The Executive Committee of the Medical Staff (ECOMS) is responsible for making recommendations directly to the Commanding Officer for approval on professional staff structure, credentials review and privileging program, peer review and organization of medical staff performance assessment and improvement activities, including the mechanism used to conduct, evaluate, and revise such activities.

e. Directorates. Each Director oversees implementation of this plan in his/her directorate.

f. Departments. Each Department Head is responsible for the overall effectiveness of performance improvement activities within their department as related to the organization. This includes internal functioning as well as integration and collaboration with other departments/divisions in the command. All must participate in the PI program. Enclosure (9) outlines department head responsibilities.

g. Performance Improvement (PI) Department. As the command department responsible for organizational improvement, the Performance Improvement Department will guide implementation of this plan.

(1) Performance Improvement Coordinator. The Performance Improvement Coordinator is a special assistant to the Executive Officer. He/she is guided by the BOD and is responsible for developing and implementing this plan.

(2) Performance Improvement Physician Advisor (PIPA). The PIPA is a member of the Executive Committee of the Medical Staff (ECOMS) and is responsible for:

(a) Informing ECOMS of PI issues related to medical staff.

(b) Working with the PI Coordinator and Risk Manager (RM) to coordinate organization PI and RM activities related to medical staff issues.

(c) Review medical staff committee minutes and Unexpected Event Reports involving medical staff to assure compliance with medical staff bylaws, proper peer review, confidentiality, and appropriateness.

(3) Risk Manager. The Risk Manager is responsible for identifying areas of potentially avoidable risk. Although this is a systematic function of the organization and is carried out in the design, measurement, assessment and improvement of every process throughout the organization, there are certain issues that are reviewed at the organizational level for possible risk abatement. These issues or organization wide risk indicators are:

(a) Sentinel Events/Potentially Compensable Events

(b) Manual of The Judge Advocate General (JAGMAN) Medical Investigations (Preliminary Investigations, Command Investigations, Litigation Reports, and Courts and Boards of Inquiry)

(c) Patient, staff, and visitor accidents

(d) Customer complaints/concerns

(h) Professional Affairs Office. The Professional Affairs Office manages the Credentials Review and Privileging Program and ensures individual compliance in accordance with reference (c). This program encompasses planning, designing, and carrying out review and privileging functions, liaison with all departments and advisory responsibilities with ECOMS.

7. Action. PI is an “all hands” evolution. All Naval Hospital personnel are required to participate in the hospital’s PI processes. They should understand the objectives and implementation procedures of the program in their department/clinical area. Addressees will comply with the requirements set forth in the instruction.

8. Reporting. PI activity reporting is delineated in enclosure (3).

9. Plan. The following pages include the JCAHO standards from the Performance Improvement Chapter and the methodology for implementation.

10. Applicability. This instruction is applicable to all personnel aboard Naval Hospital Twentynine Palms, California.

R. S. KAYLER

Distribution:
List A

NAVHOSP29PALMSINST 6010.9C
12 March 1997

Naval Hospital Twentynine Palms
Performance Improvement Plan

1. Purpose. Naval Hospital Twentynine Palms recognizes the need for an ongoing Performance Improvement Program which objectively and systematically measures, and assesses its systems and processes to improve performance for internal and external customers, with the goal of improving patient health care outcomes. Performance is what is done and how well it is done to provide health care. The level of performance in health care is the degree to which what is done is efficacious and appropriate for each patient; and the degree to which it is available in a timely manner to patients who need it, effective, acceptable, continuous with other care and care providers, safe, efficient, caring and respectful of the patient. It should meet or exceed their expectations and result in satisfied customers.

2. Enclosures. The framework for improving performance and outcomes diagramed in enclosure (4), demonstrates a functions oriented approach to performance improvement.

Enclosure (5) provides a glossary of terms used within this plan. Included is a list of the important functions that are defined in the Joint Commission Accreditation Manual for Hospitals (JCAHO).

The strategic plan of this command, enclosure (6), is based upon the command's vision, mission, and guiding principles, enclosures (7),(8), and (9).

There is a direct relationship between the existing strategic plan and the JCAHO functions. Primary responsibility for overseeing the PI activities for each JCAHO function is designated in enclosure (10). Also, included are other PI structures that are aligned with the various functions.

Enclosure (2) defines departmental responsibilities for management and continuous performance improvement, with enclosure (11) noting the mechanism by which summaries should be submitted to the PI department.

Enclosure (3) diagrams the PI information flow.

2. Groups

a. Quality Management Boards (QMB). QMBs are chartered by the Board of Directors and are typically composed of individuals in the command who have a stake or ownership in the success or future of the process under consideration.

b. Process Action Teams (PAT). PATs are chartered by the BOD or QMB when either identifies a specific area or stage within the process that needs investigation. The PAT is a temporary team that comes together to look at a specific process, measure or cause. Its primary focus is to collect and analyze data. The PAT activities are directed and supported by the chartering body.

c. Workgroup/Team/Committee/Department. Composed of individuals who have identified a process for improvement in which they have a stake or ownership. If the workgroup is not a standing team/committee/department, the PI department should be notified of its formation before the first meeting to prevent duplication of effort and provide guidance if necessary.

3. Approach

a. Process. The process for improvement should generally be selected based upon the command strategic plan, goals, and strategies as set forth in enclosure (6). The improvement process that should be used is the FOCUS PDCA process for improving performance and outcomes which is diagramed in enclosure (4). Any process or system that impacts on hospital performance may be selected to be studied for improvement.

b. Quarterly Performance Improvement Summary. The Quarterly Performance Improvement Summary sheet is needed to identify key dimensions of performance and functions that the process impacts. This summary sheet is to be completed at least quarterly and submitted to the PI department at the beginning of each new quarter. All PI activities will be reported utilizing enclosure (11).

c. Initiation of a Process Improvement Activity. It is strongly recommended that any workgroup, team, committee, or department that has stake or ownership in a process that requires improvement, contact the PI Coordinator prior to proceeding with the performance improvement activity to prevent duplication and provide guidance.

4. Reports. The PI Coordinator will summarize command PI activities and present this information to the BOD at least quarterly.

DEPARTMENT HEAD RESPONSIBILITIES

- ✔ Integrating the department into the organization's primary functions.
- ✔ Coordinating and integrating interdepartmental and intradepartmental services.
- ✔ Developing and implementing policies and procedures in collaboration with associated departments/services that guide and support the provision of services.
- ✔ Reviewing and revising policy and procedure manuals annually.
- ✔ Recommending a sufficient number of qualified and competent persons to provide care services.
- ✔ Determining the qualification and competence of department personnel who provide patient care services and who are not privileged providers.
- ✔ Maintaining quality control programs, as appropriate(cardiac arrest drills, crash carts, medications).
- ✔ Orienting and providing in-service training and continuing education of all persons in the department.
- ✔ Recommending space and other resources needed by the department.
- ✔ Participating in the selection of sources for needed services not provided by the department.
- ✔ Completing an quarterly report of performance improvement activities.
- ✔ Communicating performance improvement activities to the PI Coordinator on a quarterly basis using enclosure (1).

<u>Medical Staff Department Heads also have the following responsibilities:</u>

To monitor all clinically related activities on a continuing basis including , but not limited to:

- ➔ Operative, Other Invasive, and Noninvasive Procedures
- ➔ Medication Use
- ➔ Use of Blood and Blood Components

To monitor all department administrative activities.

To provide continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the department.

To recommend to the medical staff the criteria for granting clinical privileges in the department.

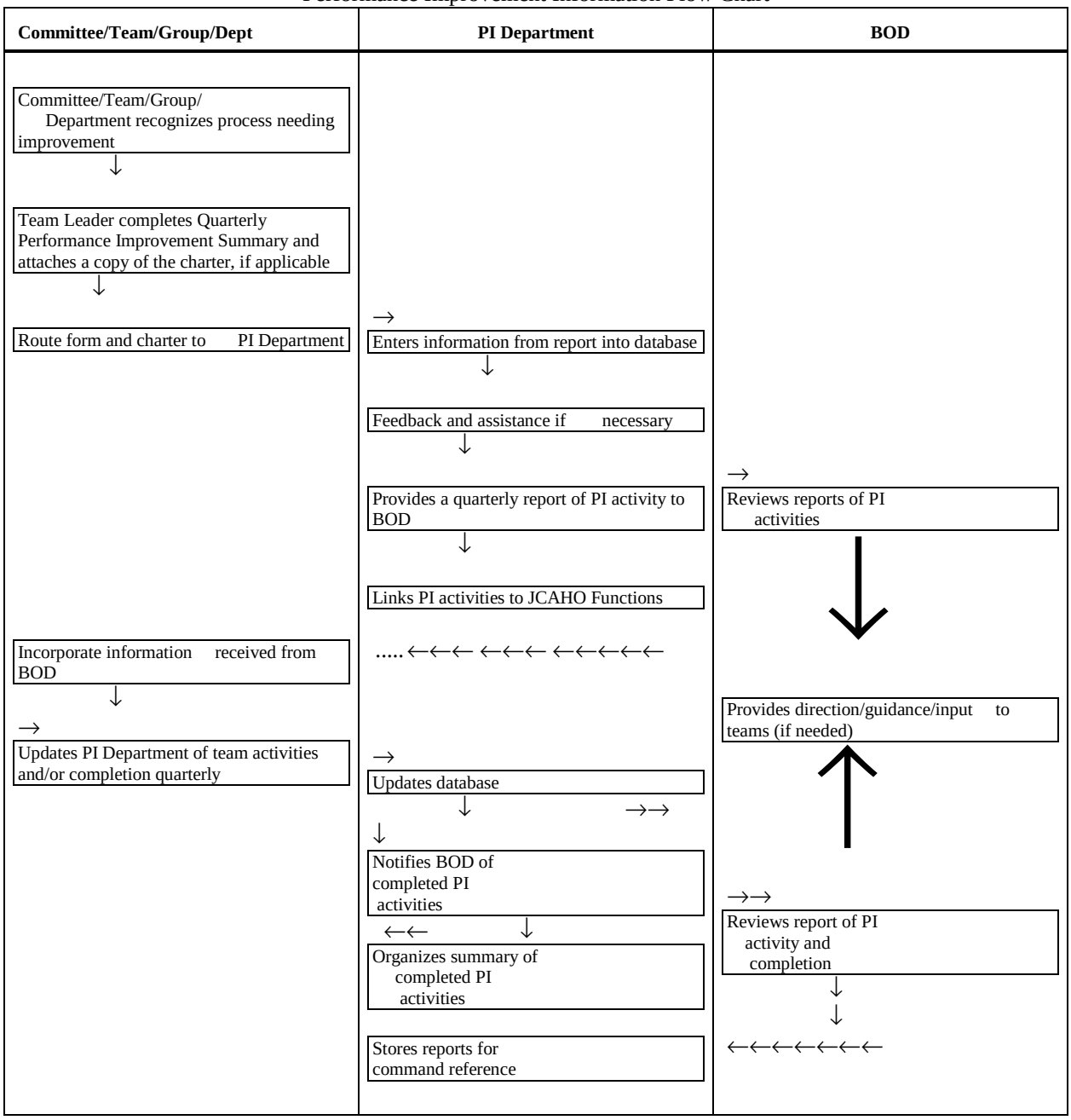
To assess and recommend to the BOD off site sources for patient care services not provided by the department.

DEPARTMENTS PROVIDING PATIENT CARE THAT ARE NOT MEDICAL STAFF DEPARTMENTS ARE DIRECTED BY AN INDIVIDUAL WHOSE AUTHORITY, AND DUTIES ARE DEFINED IN WRITING AS PER reference (d).

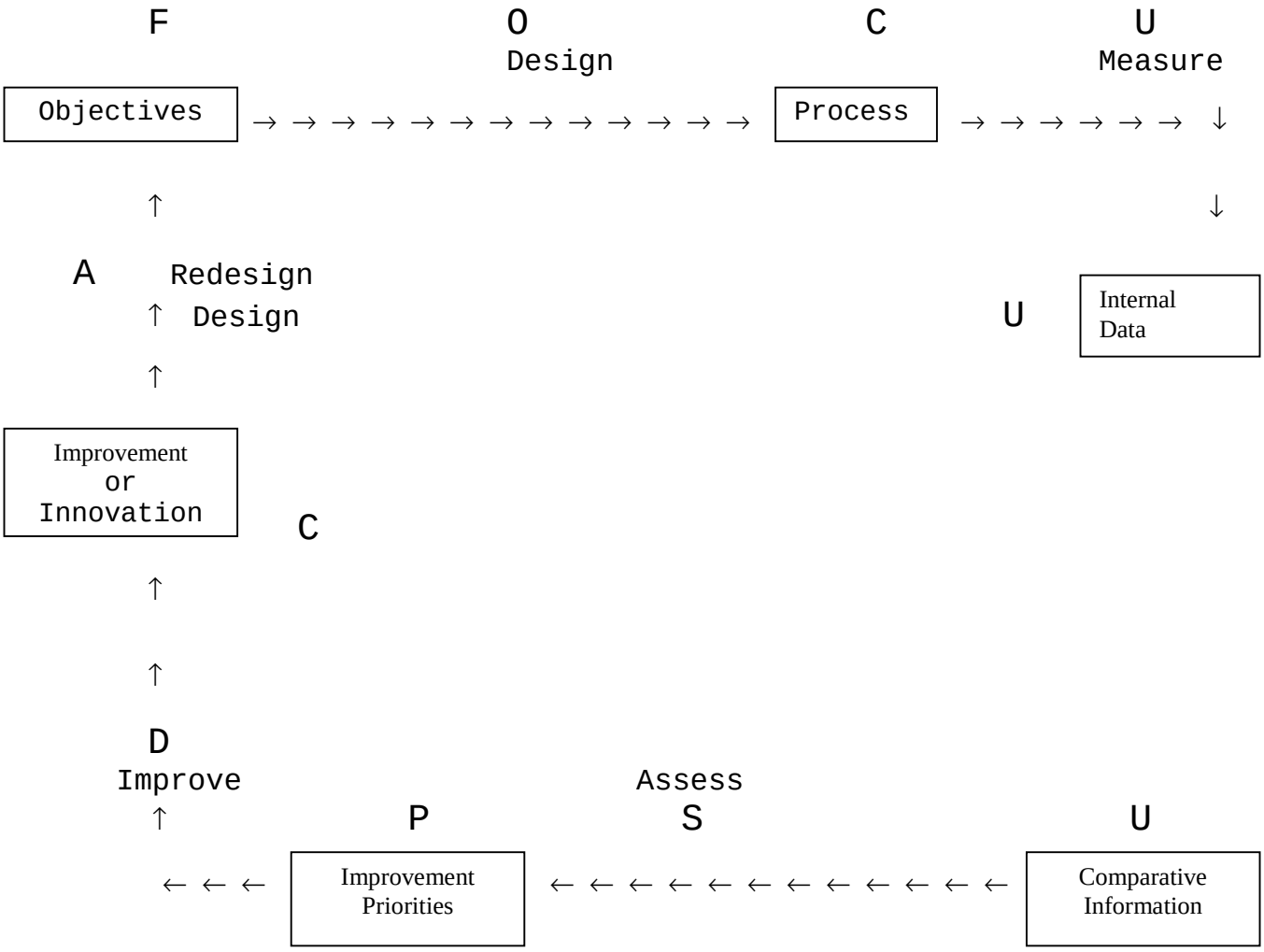
To have responsibility for administrative direction and clinical direction as defined.

Clinical direction of patient care and treatment services is the responsibility of a qualified professional with appropriate clinical training and experience.

Performance Improvement Information Flow Chart



Performance Improvement Cycle



F Find a process to improve.
O Organize to improve process.
C Clarify current knowledge of the process.
U Understand the sources of process variation.

P Plan the improvement.
D Do the improvement to the process.
C Check the results.
A Act to hold the gain and continue to improve the process.

GLOSSARY

FUNCTIONS: LISTED IN Joint Commission Comprehensive Accreditation Manual for Hospitals (CAMH)

PATIENT-FOCUSED FUNCTIONS:
PATIENT RIGHTS AND ORGANIZATIONAL ETHICS
ASSESSMENT OF PATIENTS
CARE OF PATIENTS
EDUCATION
CONTINUUM OF CARE

ORGANIZATIONAL FUNCTIONS:
IMPROVING ORGANIZATION PERFORMANCE
LEADERSHIP
MANAGEMENT OF HUMAN RESOURCES
MANAGEMENT OF INFORMATION
MANAGEMENT OF THE ENVIRONMENT OF CARE
SURVEILLANCE, PREVENTION, AND CONTROL OF INFECTION

CHARACTERISTICS:
Emphasizes the multi disciplinary performance of important functions rather than department-specific activities.

Performed to achieve desired goals/outcomes. Composed of processes.

May be fully, marginally, or only barely visible to patients.

Emphasizes actual performance rather than the capacity to perform.

Supports an approach to performance planning, designing, measuring, assessing and improving that stresses coordinated, integrated, and efficiently provided services.

Measurable using dimensions of performance.

STRUCTURES WITH FUNCTIONS:
GOVERNANCE - Sets the organization policy that supports quality patient care. It develops the mission, vision, policies, and bylaws that direct the hospital’s operations.

MANAGEMENT - The responsibilities of the Commanding Officer and Board of Directors and the relationship between the governing body and the Commanding Officer.

MEDICAL STAFF - Medical staff actively participate and exercise professional leadership in measuring, assessing, and improving the performance of the organizations within which they work. Medical staff leadership occurs at various levels within the organization and participates in assessing and improving the quality of care delivered in health care organizations at all levels.

NURSING - The nurse executive:

- *Ensures the continuous and timely availability of nursing services to patients;
- *Ensures that nursing standards of patient care and standards of nursing practice are consistent with current nursing research findings and nationally recognized professional standards;
- *Ensures that nursing service staff carry out applicable processes in the patient care and organization wide functions described in the JCAHO CAMH;
- *Assigns responsibility to individuals or groups of nursing staff members to act on improving the nursing service's or the hospitals performance;
- *Actively participates in the hospital's leadership functions;
- *Collaborates with other hospital leaders in designing, improving and providing patient care and services;

DIMENSIONS OF PERFORMANCE

I. Doing the Right Thing

Appropriateness - the degree to which the care provided is relevant to the patient's clinical needs, given the current state of knowledge.

Efficacy - the degree to which the care of the patient has been shown to accomplish the desired or projected outcome(s).

II. Doing the Right Thing Well

Availability - the degree to which appropriate care is available to meet the patient's needs.

Continuity - the degree to which the care of patients is coordinated among practitioners, among organizations, and over time.

Effectiveness - the degree to which the care is provided in the correct manner, given the current state of knowledge, to achieve the desired or projected outcome for the patient.

Efficiency - the relationship between the outcomes (results of care) and the resources used to deliver patient care.
Respect and Caring - the degree to which those providing services do so with sensitivity for the patient's needs, expectations, and individual differences. The degree to which the patient or a designee is involved in his or her own care decisions.

Safety -the degree to which the risk of an intervention and risk in the care environment are reduced for the patient and others, including the health care provider.

Timeliness - the degree to which care is provided to the patient at the most beneficial or necessary time.

Respect and Caring - the degree to which the patient or designee is involved in his or her own care decisions and to which those providing services do with sensitivity and respect for the patient's needs, expectations, and individual differences.

BENCHMARK: An approach to establishing operating goals and productivity based on best-industry practices. A point of reference designed to answer the common questions such as "Is our rate high or low?" and "How do we compare to similar facilities?".

PERFORMANCE MEASUREMENT - a FUNCTIONS-ORIENTED APPROACH: The quantification of processes and outcomes using one or more dimensions of performance, such as availability and timeliness, the first segment of a performance measurement, assessment, and improvement system.

FOCUS-PDCA (See enclosure (4))
Find a process improvement opportunity
Organize a team who understands the process
Clarify the current knowledge of the process
Uncover the root cause of variation and poor quality
Start the "plan-do-check-act" cycle

Plan the process improvement
Do the improvement, data collection, and analysis
Check the results and lessons learned
Act by adopting, adjusting, or abandoning the change

FUNCTIONS ORIENTED HEALTHCARE ORGANIZATION: A healthcare organization is a system composed of a group of interconnected functions carried out to increase the probability of desired patient health outcomes.

FUNCTION: A function is a goal-directed interrelated series of processes, such as patient assessment or patient care.

PROCESS: A process is a goal directed, interrelated series of actions, events, mechanisms, or steps.

OUTCOME: That which results from performance (or nonperformance) of a function(s)or process(es). An outcome represents the cumulative effect of one or more processes on a patient at a defined point in time, as in patient survival (or death) following a medical intervention.

MEASUREMENT: The systematic process of data collection, repeated over time or at a single point in time.

INDICATOR: 1. A valid and reliable quantitative process or outcome measure related to one or more dimensions of performance such as effectiveness and appropriateness. 2. A statistical value that provides an indication of the condition or direction over time of an organization’s performance of a specified process, or an organization’s achievement of a specified outcome. For example, in most hospitals, a primary c-section rate of 32% is an indicator of the organization’s need to further investigate this process of care.

QUALITY OF CARE: The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. Dimensions of quality include the following: patient perspective issues, safety of the care environment, and accessibility, appropriateness, continuity, effectiveness, efficiency, efficacy, and timeliness of care.

STRATEGIC PLAN

Strategic Goal 1: Readiness

Naval Hospital Twentynine Palms will vigorously support the operational readiness of Combat Center Forces and meet or exceed all readiness standards for hospital staff.

Strategies:

1.1 We will focus our health care delivery and wellness programs to support the readiness of Combat Center forces.
1.2 We will provide our staff with the education, training, health care delivery and wellness programs required to meet or exceed all readiness standards and mobilization requirements.
1.3 We will maintain a disaster preparedness program that can respond effectively to any reasonably foreseeable contingency.

Strategic Goal 2: Staff

Naval Hospital Twentynine Palms will maintain optimal staffing and foster excellence and commitment in a quality environment.

Strategies:

2.1 We will maintain staffing to meet the command mission.
2.2 We will encourage every member of the command to reach their full potential by providing the very best opportunities for professional and personal growth consistent with our mission.
2.3 We will enhance the quality of life of staff.
2.4 We will develop a team building plan.

Strategic Goal 3: Technology Integration

Naval Hospital Twentynine Palms will incorporate technology that will improve the quality, cost-effectiveness, and accessibility of health care delivery.

3.1 We will implement integrated information systems for clinical, resource, and administrative functions.

3.2 We will define a baseline of computer literacy by user, and ensure that users are trained to meet at least the minimum requirements established by this baseline.

3.3 Review and refine equipment management program processes.

Strategic Goal 4: Health and Wellness Services

Naval Hospital Twentynine Palms will ensure beneficiaries have timely access to high quality, cost-effective health care, health promotion and wellness services.

Strategies:

4.1 We will ensure catchment area beneficiaries enrolled at NHTP will be empaneled to a specific health care team that manages their clinical care.

4.2 We will make health promotion and wellness services an integral and essential part of primary health care.

4.3 We will optimize resources to provide high quality, cost effective, accessible health care for all beneficiaries.

Vision

We are a modern healthcare organization where:

☞ *Staff, patients, families, and the commands we support are united in achieving optimal health, wellness and readiness.*

☞ *Staff enjoy coming to work.*

☞ *Patients and their families brag about timely access to high quality, compassionate care.*

MISSION

We are the principal military health care facility in support of Marine Corps Air Ground Combat Center.

We support operational readiness by providing comprehensive health care services to Marines,

Sailors, and their families. We serve the health care needs of all beneficiaries in our area.

GUIDING PRINCIPLES

- *We do what is right for the patient.*

- *We value teaching and education.*

- *We are people-focused and value individual worth.*

- *We empower our staff for continuous quality improvement.*

- *Our success comes from teamwork.*

- *We believe positive attitudes create a healing environment.*

PI MANAGEMENT RESPONSIBILITY FOR JCAHO FUNCTIONS

JCAHO FUNCTION	STRATEGIC GOAL	RESPONSIBILITY
Patient Rights and Organizational Ethics (RI)	Strategic Goal #2 Strategic Goal #4	BOD, Directors, Department Heads, Bioethics Committee, Patient Contact
Assessment of Patients (PE)	Strategic Goal #4	BOD, Directors, Department Heads, Medical Records Review Committee
Care of Patients (TX)	Strategic Goal #4	BOD, Directors, Department Heads, TRICARE, Pharmacy, P&T Committee
Education (PF)	Strategic Goal #4	BOD, Directors, Department Heads, Education and Training, Nurse Educator/Discharge Planner
Continuum of Care (CC)	Strategic Goal #4	BOD, Directors, Department Heads, TRICARE, Utilization Management
Leadership (LD)	Strategic Goal #4	BOD, Directors, Department Heads
Management of Human Resources (HR)	Strategic Goal #2	BOD, Directors, Department Heads, HRO, Manpower
Management of Information (IM)	Strategic Goal #3	DFA, BOD, Department Heads, MID
Management of the Environment of Care (EC)	Strategic Goal #4	BOD, Directors, Department Heads, Safety Committee
Improving Organizational Performance (PI)	Strategic Goal #2	All Staff
Surveillance, Prevention, and Control of Infection (IC)	Strategic Goal #4	BOD, Directors, Department Heads, Occupational Medicine, Preventive Medicine, Infection Control Committee

QUARTERLY PERFORMANCE IMPROVEMENT SUMMARY

Workgroup/Team/Committee/Department: Quarter Reported:

Process:

	DIMENSION OF PERFORMANCE		FUNCTION
	Efficacy		Improving Organizational Performance
	Appropriateness		Assessment of Patients
	Availability		Care of Patients
	Timeliness		Education of Patients and Family
	Efficiency		Continuum of Care
	Effectiveness		Leadership
	Continuity		Management of Information
	Safety		Management of Human Resources
	Respect and Caring		Management of Environment of Care
			Surveillance, Prevention & Control of Infection
			Patient Rights and Organization Ethics

1. Describe the process that has been identified for improvement? (Include goal or benchmark.)

2. If this process improvement activity was initiated prior to this quarter, what action for improvement has been initiated, has the action been effective, and what improvements in patient care or the process have resulted from this action?